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Important note
In line with its election commitment, the Government planned to close the Medicare chronic disease dental scheme to all patients by 1 July 2008, and to re-direct the savings to its new dental programs (Commonwealth Dental Health Program and Medicare Teen Dental Plan). However, on 19 June 2008, the Senate blocked the scheme's closure. On 16 September 2008, the Senate blocked the Government's second attempt to close the scheme.

Therefore, the scheme remains open and all eligible claims will be paid.

It remains the Government's intention to close the scheme in order to make funding available for its new dental programs, and the Government will continue to explore policy options in an effort to improve access to dental treatment services for all Australians. Patients receiving services under the chronic disease dental scheme will be advised of any changes to the scheme.

This fact sheet is a summary of the Medicare dental items and what these arrangements mean for GPs. There are also separate fact sheets for dentists/dental specialists, dental prosthetists and patients. More detailed information is available in the Medicare Benefits Schedule (MBS) Book and the MBS Dental Services book.

PDF printable version of Fact sheet for GPs (PDF 223 KB)

If you have any difficulty accessing the PDF, please contact acd.webmaster@health.gov.au

Summary:

- Medicare dental items (items 85011-87777) cover services provided by dentists, dental specialists and dental prosthetists in their surgeries (i.e. services to admitted hospital patients are not covered).
- The patient must be referred by their GP for dental services.
- Eligible patients can receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years.
- Eligible patients are those with a chronic medical condition and complex care needs being managed by their GP under a GP Management Plan and Team Care Arrangements, or a multidisciplinary care plan for residents of aged care facilities.
- The patient's oral health must also be impacting on, or likely to impact on, their general health.
- Dental practitioners may set their own fees. In some cases, patients may have out-of-pocket costs.

Eligible patients
To be eligible, a person must have a chronic medical condition and complex care needs (ie be managed by a GP under the following care plans). The patient's oral health must also be impacting on, or likely to impact on, their general health.

Whether the patient is eligible for referral for dental services is a clinical judgement for the GP, taking into account the patient's condition and care needs.

The care planning requirements are the same as those under the EPC allied health items, and the existing EPC dental items, ie the patient must have received the following services from a GP within the previous two years:

- GP Management Plan (item 721 or a review under item 725) and Team Care Arrangements (item 723 or a review under item 727); or
- for residents of an aged care facility, their GP must have contributed to or reviewed a multidisciplinary care plan prepared for the resident by the facility (item 731).

Further information on these chronic disease management items is set out in the MBS Book.

If these GP care planning items have not been claimed and paid by Medicare Australia or the patient has used their \$4,250 allocation, no Medicare benefits for dental services can be paid to the patient. The care plans cannot be done retrospectively, ie after the dental services have been provided to the patient.

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Types of dental services covered
A comprehensive range of services are covered by the dental items, including dental assessments, preventive services, restorative services such as

fillings, crowns, bridges and implants, extractions and other oral surgery (other than hospital services), orthodontic services and dentures.

The items can only be used where the primary objective of the treatment is to improve oral health or function. The items cannot be claimed for treatment that is predominantly for the improvement of the appearance of the patient (eg cosmetic). Services where the primary aim is to improve the health or function of the patient, but which also comprise a cosmetic component, may be claimed.

The items are not available to admitted hospital patients, even if the patient is admitted to a hospital solely for the purposes of that dental treatment (i.e. the items apply to out-of-hospital dental services only). The items also do not generally apply to services that are provided by Commonwealth or State funded dental services.

Eligible dental practitioners The dental items can be used by dentists, dental specialists and dental prosthetists registered with Medicare Australia. GPs are encouraged to establish links with local dental practitioners and check whether they will accept referrals under the Medicare dental items.

Medicare benefits payable Eligible patients can receive up to \$4,250 in Medicare benefits (including Extended Medicare Safety Net benefits where applicable) for dental services over two consecutive calendar years under items 85011 to 87777.

The two-year period is counted from the calendar year of the patient's first eligible dental service.

Patients, GPs and dental practitioners will be able to call Medicare Australia to check how much the patient has already received in Medicare benefits for dental services over the relevant period. GPs may call the Provider Enquiry Line on 132 150. Patients may call the Patient Enquiry Line on 132 011.

Referrals by a GP to a dental practitioner In most cases, the GP will refer the patient to an eligible dentist in the first instance.

GPs may refer a patient directly to a dental prosthetist where the patient has no natural teeth and requires dental prosthetic services only (eg full dentures), or requires repairs or maintenance to full or partial dentures.

GPs cannot refer patients directly to a dental specialist. A dentist will refer the patient onto a dental specialist, another dentist or a dental prosthetist, where required.

Referral form GPs must use the **Referral Form for Dental Services under Medicare** issued by the Department of Health and Ageing, or a form that substantially complies with this referral form. The form can be downloaded from www.health.gov.au/dental or obtained by calling the Department on (02) 6289 4297.

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New referrals The GP referral remains valid for two consecutive calendar years from the date of the patient's first dental service. Where further dental services are required to treat a new or existing oral health problem at the end of a patient's two calendar year period, the patient will need to obtain a new referral from their GP.

Informing patients about the cost of dental services When referring patients for dental services, GPs should inform patients that the dental services may not be bulk billed. Dental practitioners are free to bulk bill or set their own fees for services. In some instances, patients may incur out-of-pocket costs not covered by Medicare.

To assist patients in understanding the cost of dental treatment, dental practitioners are required to provide a written quote or cost estimate to the patient prior to commencing a course of treatment.

Reporting by the dental practitioner to the GP Dental practitioners must provide a copy or summary of the patient's treatment plan to the referring GP before beginning the course of treatment.

Cessation of EPC dental items 10975-109677
The EPC dental items 10975-10977 are no longer available. These items ceased on 31 December 2007.

Further information

- **Medicare Benefits Schedule Book** is available at www.health.gov.au/mbsonline.
- **Medicare Benefits Schedule Dental Services** dental book (effective 1 November 2009) – mainly intended for dental practitioners. Available at www.mbsonline.gov.au (PDF 185KB).
- GPs can call the Medicare Provider Enquiry Line on 132 150 for further information about the referral process and patient entitlements.

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